



SUZANNA VOGEL



BOARD CERTIFIED MASSAGE THERAPIST
ORTHOPEDIC, DEEP TISSUE, & SPORTS MASSAGE

(919)475-9416 • www.zannamassage.com

PRESCRIPTION REFERRAL *for* MASSAGE THERAPY SERVICES

FROM: Doctor _____ Date _____

Address _____

Phone _____ Fax _____

REGARDING PATIENT: _____

Treatment is medically necessary for diagnosis indicated below using the modalities and procedures check-marked below:

Modalities/Procedures

- 97124 _____ Massage Therapy
- 97140 _____ Manual Therapy Techniques
- 97010 _____ Hot or Cold Packs
- 97110 _____ Therapeutic Exercise (R.O.M)

Condition is related to:

- _____ Auto accident
- _____ Work injury
- _____ Illness
- _____ Other Date of Injury _____

Diagnosis Codes

- 354.0 _____ Carpal Tunnel Syndrome
- 723.1 _____ Cervicalgia
- 723.4 _____ Brachial Neuritis / Radiculitis (UEs)
- 724.3 _____ Sciatica
- 724.4 _____ Lumbosacral / Thoracic Neuritis / Radiculitis (LEs)
- 729.1 _____ Fibromyalgia / Myalgia / Myositis
- 784.0 _____ Headache
- 840.9 _____ Shoulders-Upper Arms Sprain/Strain
- 846.0 _____ Lumbosacral Sprain / Strain
- 847.0 _____ Cervical Sprain / Strain
- 847.1 _____ Thoracic Sprain / Strain

- 847.2 _____ Lumbar Sprain / Strain
- 847.3 _____ Sacral Sprain / Strain
- 847.4 _____ Coccyx Sprain / Strain
- 848.1 _____ TMJ Sprain / Strain

Other Dx Codes:

Duration and Frequency of Treatment

_____ times per week for _____ weeks

OR _____ treatments

OR _____

Physician's Signature _____ Date _____

License # _____ NPI # _____

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